DOCUMENT RESUME

ED 464 264 CE 083 234

AUTHOR	Cleary, Helen P.
TITLE	The Credentialing of Health Educators: An Historical Account, 1970-1990.
INSTITUTION	National Commission for Health Education Credentialing, Inc., Allentown, PA.
PUB DATE	1995-00-00
NOTE	57p.
AVAILABLE FROM	National Commission for Health Education Credentialing, Inc., 944 Marcon Blvd. Ste. 310, Allentown, PA 18109 ($5). Tel: 888-624-3248 (Toll Free); Fax: 800-813-0727 (Toll Free); Web site: http://www.nhec.org.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Adult Education; *Adult Educators; Advisory Committees; *Certification; Conferences; Continuing Education; Credentials; Curriculum Development; Definitions; Educational History; Educational Needs; Employment Patterns; *Employment Qualifications; Entry Workers; *Health Education; Health Promotion; Higher Education; National Organizations; National Standards; Needs Assessment; Organizational Development; Organizational Objectives; Professional Development; Public Health; *Standard Setting; Systems Approach; *Teacher Education; Workshops
IDENTIFIERS	Certified Health Education Specialists; Professionalization

ABSTRACT

Development of the credentialing system for health education specialists began in February 1978, when a conference was convened to consider the profession's interest in credentialing and develop an initial role specification for entry-level health educators. In the early 1980s, the role specification was verified and refined, the process of developing a curriculum for health education specialists was initiated, and draft and revised curricula were developed and distributed. The National Commission for Health Education Credentialing (NCHEC) was established in 1988. Charter certification was initiated in 1989, and 1,558 health education specialists were certified through examination of credentials. The first certification examination for health education specialists was offered in 1990 at 16 sites across the United States. Development of procedures for a continuing education system for health education specialists began in 1990. Refinement and expansion of the certification system and continuing education systems continued in the early 1990s. The following issues were identified and addressed: communications; program content; working with employers of health educators; "defining entry level"; and unifying the profession. Appended are: a chronology of the development of national certification for health education specialists; definitions of credentialing terminology; lists of committees and task force members; and recommendations of the first Bethesda conference. (MN)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 464 264

THE CREDENTIALING OF HEALTH EDUCATORS: AN HISTORICAL ACCOUNT 1970-1990

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

K. B. Alley

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

2B

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Helen P. Cleary
D.Sc., CHES

CE083234

BEST COPY AVAILABLE

2

The Credentialing of Health Educators: An Historical Account 1970-1990

by

Helen P. Cleary
D.Sc., CHES

Copyright © 1995. All rights reserved.
Published by
THE NATIONAL COMMISSION FOR
HEALTH EDUCATION CREDENTIALING, INC.
944 Marcon Boulevard, Suite 310
Allentown, PA 18103

This book was set in Times Roman by Pat McCarney.
Production supervised by Ann E. Nolte.
For the NCHEC Publications Committee by Marian V. Hamburg, Anne Nolte, and William C. Livingood.

CONTENTS

Foreword iii
Preface vi

INTRODUCTION 1

CHRONOLOGY 3

- Pre-Task Force Activity 3
- Birth of the Task Force 4
- The Work Begins 5
  - Role Delineation 5
  - Role Verification and Refinement 6
- The Task Force Carries On 7
  - Birmingham Conference 8
  - Curriculum 9
    - Curriculum Guide 9
    - Regional Workshops 11
    - Curriculum Framework 12
  - Self-Assessment/Continuing Education 12
  - Checking with the Profession (Second Bethesda Conference) 13
    - The Plan of Action 15
  - Certification of the Individual 16
  - Accreditation 17

ADMINISTRATION 21

- The Task Force 21
- Finances 22
- Volunteers and Office Space 24

PARALLEL AND RELATED ACTIVITIES 26

PROBLEMS 28

ISSUES 31

- Communications 31
- Content 32
- Working with Employers of Health Educators 33
- What is Entry Level? 34
- Unification of the Profession 35

CONCLUSION 36

REFERENCES 37

APPENDIX A: The Development of National Certification for Health Education Specialists; A Chronology 38

APPENDIX B: Definitions of Credentialing Terminology 42

APPENDIX C: Lists of Committees and Task Force Members 43

APPENDIX D: Recommendations of the First Bethesda Conference 46

FOREWORD

This history was written by the person most responsible for the establishment of certification for health education specialists: Helen P. Cleary. It was her determination, energy, and skill that led finally to the creation of the National Commission for Health Education Credentialing, an idea that had long been discussed among health education professionals. This is her account of how it came about. The NCCHE is proud to be its publisher and distributor and acknowledges with thanks the generosity of the Association for the Advancement of Health Education in preparing the initial draft.

Helen P. Cleary

Helen P. Cleary was born in Bookline, Massachusetts, on February 8, 1920. After earning an AB degree in mathematics from Regis College, Weston, Massachusetts, her first position was as a teacher of mathematics and science at the St. Luis School in Colorado Springs, Colorado. She reports that she was well prepared to teach mathematics, but to her surprise, was also assigned to teach biology and she kept just one step ahead of her pupils. In

1943, Helen enlisted in the United States Marine Corps and was stationed in North Carolina. She retired in 1965 with the rank of Lt. Colonel.

Returning to Massachusetts at the close of WWII, Helen was first employed as a health educator by the Lynn Tuberculosis and Health League (1946-47) and next by the Norfolk County Tuberculosis Association (1947-49). The national organization encouraged staff members to seek additional training.

In 1949, Helen returned to school and in 1950 received the MPH in Health Education from Yale University. On graduation from Yale she worked as a health educator at the Boston Health Department and for five years (1951-56) as an educator at the Quincy, Massachusetts, Health Department. In 1956 she left the Quincy Health Department to staff the Rehabilitation Council of Metropolitan Boston. Building upon her interest in the handicapped and past experiences, Helen joined the Massachusetts Association for the Blind as its Executive Director. She held this position from 1956-67.

In February 1967, she enrolled in a doctoral program at the Harvard School of Public Health from which she received the degree of Doctor of Science (D.Sc.) in Health Services Administration in 1970. Her doctoral thesis addressed the effect of values on behavior in a rehabilitation setting. Then began a busy period not only in respect to job responsibilities but also in respect to involvement and assumption of leadership roles in health education affairs on the state, regional, and national scenes.

For a two-year period (1970-72), as Coordinator of Rhode Island's Regional Medical Program, Helen promoted with staff and Board the concept of regionalization. The next two years were spent as a Senior Fellow at the Harvard Center for Community Health and Medical Care. From 1970-74, she was an Instructor of health education at the Harvard School of Public Health. From 1974 until her retirement in 1987, Helen was an Associate Professor in the Department of Family and Community Medicine of the University of Massachusetts Medical School.

In 1965, Helen was elected and served as Selectman [sic] for the Town of Norfolk, Massachusetts, until 1971. She was a board member of the Worcester Visiting Nurse Association, active with the Central Massachusetts Division of the American Health Association and Chairperson of a Public Education committee of the Central Massachusetts Health Systems Agency. Articles by Helen appeared in such journals as the *Health Education Quarterly*, *Worcester District Medical Society*, and *The Eta Sigma Gamma*. *Advancing Health Education Through Education: A Case Study Approach* was published in 1985 in collaboration with Jeff Kichen and Phyllis Ensor.

Among her professional activities in the 1970s were service as President of the New England Chapter of the Society for Public Health Education, member of the Governing Council of the American Public Health Association, President of the Society for Public Health Education, and initiation of the work of the National Task Force on the Preparation and Practice of Health Educators. In visiting health education groups in various parts of the country as President-Elect of SOPHE (1974-75), Helen became acutely aware of the need for a better definition of the specific responsibilities and competencies of the health educator. Too many practitioners were unsure of their role and unable to

explain it to others.

The identification of the need for clarification of the roles and responsibilities of health educators led to an enterprise that engaged Helen Cleary's energies for a decade, namely, the National Task Force on Preparation and Practice of Health Educators as its chairperson. Except for federal funding for the Role Delineation and Verification studies, which were administered by the National Center for Health Education, the Task Force operated with minimal funding, relying primarily on the "kindness of friends." There were no paid staff. Helen gave the equivalent of expert full-time staff service and was blessed with the support of other committed Task Force members. Helen's energy, persistence, and vision were instrumental in keeping the Task Force on course in completing its mission. When metamorphosis from Task Force to National Commission for Health Education finally came in 1988, Helen relinquished her relationship with the endeavor.

Recognition from her peers abounded. The Association for the Advancement of Health Education presented her with its Presidential Citation Award; Eta Sigma Gamma gave her its Distinguished Service Award and Helen was designated a Distinguished Fellow by the Society for Public Health Education.

Helen Cleary's interests encompass family, friends, church, and community as well as health education and public health concerns. These interests extend to gardening and especially herb growing. As a matter of fact, it is possible to purchase, at some New England farm markets, packaged dried herbs bearing the label "Prepared for you with organically grown herbs by HPC's Kitchen." And, in some ways, herbs epitomize Helen-pungent, spicy, tantalizing, and invigorating.

The NCCHE is grateful to Eta Sigma Gamma, the National Professional Health Science Honorary, for permission to reprint Dr. Cleary's biography from Skiff, A. (1990). Helen P. Cleary in *Key Leaders in Health Education: A Century of Commitment*. Eta Sigma Gamma Monograph Series, 8(2), 47-48.

PREFACE

This publication is an account of the development of a credentialing system for health education specialists, the system now administered by the National Commission for Health Education Credentialing (NCHEC). As in any historical account, it is not possible to include everything that was done nor to mention everyone involved. In terms of the latter, NCHEC never would have been possible had it not been for the thousands of hours of professional service contributed to the effort by hundreds of health education specialists throughout the country. Nor would it have been possible had not the Director and staff of the Division of Associated Health Professions, Bureau of Health Manpower, HEW, in 1978 and 1979 believe in the importance of health education sufficiently to grant two federal contracts to delineate and verify the role of the health education specialist.

Credentialing terminology is confusing to the uninitiated; it certainly took those of us involved some time to separate accreditation from licensure, certification, and registration and each of the last three from one another. So for those readers not familiar with these terms, they are defined in Appendix B.

We learned, early on, that developing a credentialing system for a profession involved defining *generic, entry level* skills or competencies. It is important to keep this in mind. Many people wanted competencies defined at advanced levels of practice and for specific work settings. In time, all of these can be done. I believe advanced level competencies are needed; however, we must crawl before we walk. Without generic, entry-level competencies as a basis, competencies cannot be defined at any other level.

I have dealt with the question of "why credentialing for health education specialists elsewhere" (Cleary, 1986). It is sufficient to say here that a credentialing system is not the total answer to any profession's problems, but it can improve the quality of professional preparation and of professional practice. It can also help a profession organize itself. But none of this is possible unless the profession is willing to work to make it happen.

In terms of what is reported in this history, all of us are subject to selective perception. So, this account is my perception of the effort.

In February 1978, when the first Bethesda Conference was convened to consider the profession's interest in credentialing, the credentialing concept was not new to health educators.

In the early seventies, members of the profession in the public health field were very concerned about the accreditation of programs preparing community health educators which were located in non-schools of public health. At that time, accreditation was carried out by the American Public Health Association (APHA) which had accredited seven of these programs by 1974. However, APHA was about to lose its accreditation certification by the Office of Education and the Council on Post-Secondary Accreditation. Therefore, it was gradually divesting itself of credentialing activities. In 1974, APHA and the Association of Schools of Public Health created the Council on Education for Public Health (CEPH) whose major function was the accreditation of schools of public health. The Professional Examination Service was organized to develop examinations for a number of technical specialties in public health.

Public health educators urged CEPH to consider continuing the accreditation of public health-related programs, as well as graduate schools of public health, to reduce the proliferation of programmatic accreditation (letter, January 8, 1976, from Janet Strauss, CEPH Executive, to J. Lovegren, SOPHE Executive Director). At its January 29-30, 1976, meeting, "The APHA Committee on Accreditation of Community Health Education Programs agreed to accept CEPH's offer to shift the major elements of its own accrediting function to CEPH at the earliest possible date" (Green, 1976).

The health education specialists were as active in offering suggestions to CEPH as they had been to APHA as to how the graduate programs in health education outside schools of public health might be accredited (Green, 1976). Also, in the early seventies, a Society for Public Health Education (SOPHE) committee was working on a self-study document to be used in a SOPHE program approval process for undergraduate programs in community health education.

It should be noted that the concern for accreditation was restricted to the public health segment of the health education field. Those in school health did not have similar concerns since the universities and colleges in which school health programs were located had long been accredited by their state departments of education and sometimes by the National Council for Accreditation of Teacher Education (NCATE). That segment of the field, however, had held a number of conferences over the years on the professional preparation and practice of the health education specialist (Creswell, 1981).

Credentialing of the individual health educator, which could take the form of licensure, certification, or registration, was not in effect in the seventies with two exceptions: (1) Those who taught health in the junior high and high schools were required by most states to be certified in order to teach. States, however, varied greatly in their health certification standards. (2) In 1980, the North Carolina Chapter of the Society for Public Health Education developed a registry for health educators. To be registered required graduation with a major

in health education and references from professional colleagues, one of whom must be a health educator, and an agreement to practice the current SOPHE Code of Ethics. To broaden the base of participation to health educators working in all settings, the Board of Registry was granted a "charter as a corporate entity in the State of North Carolina in October 1988" (January 1991, *The R.H.Ed. Report*, N.C. Board of Registry for Health Education, Inc.).

At about the same time (mid-seventies), the Coalition of National Health Education Organizations, working under a grant from the Centers for Disease Control, published a report (*Report on Current Status and Need for Health Education Performance Standards and Recommendations for Action*) recommending that performance standards be developed and identifying the need for a knowledge-based philosophy, a code of ethics and the cooperation of all coalition organizations to act on these recommendations. This report is not dated, but the bibliography suggests it was published around 1977.

In 1974, SOPHE appointed a committee to update its 1967 report on the Preparation and Practice of the Health Educator. The committee, chaired by Helen Ross, submitted its report to the SOPHE Board in 1976, *Guidelines for the Preparation and Practice of Professional Health Educators.* It was this report which led me to ask, "What use can this be put to in the field?" "How can we translate it into standards that will be meaningful; i.e., that can be applied in all practice settings and can be set up in such a way that those practicing health education will be required to live up to them?" I was, of course, describing some type of credentialing system, but I did not know that at the time.

That report, along with my visits to the SOPHE chapters the year before I assumed the presidency of SOPHE in the fall of 1975, persuaded me that the field was in desperate need of implementation of the concepts delineated in the report. What I found in my travels was a profession in disarray. Many, many health educators could neither define themselves nor their role. It was clear that the preparation of most was so varied that there was no common core. There was no professional identity, no sense of a profession. Numbers of competent, bright, young professionals were leaving health education for greener pastures. Who could blame them? It was a most discouraging picture.

The firm belief that education was the most promising intervention we had or would have for some time for the prevention of disease and the promotion of health persuaded me that it was worth trying to clean up our act.

CHRONOLOGY

This section traces the development of the credentialing system from its inception through the organization of NCHEC. Appendix A provides a concise chronology (in outline form) for easy reference of the following events.

PRE-TASK FORCE ACTIVITY

I took the report of Helen Ross's Committee and began to ask knowledgeable people how it could be translated into useful standards. One of these was Dr. Lillian Terris, President of the Professional Examination Service. She told me the form in which this report was written did not allow for translation into standards. This required a process which the profession could not do alone. It required the assistance of those with expertise in role delineation, verification, and examination development. This, of course, would cost money. I asked where money might be available. Dr. Terris gave me three names—one in the Department of Education, one in the Department of Labor, and one in the Bureau of Health Manpower in HEW (now HHS). Thomas Hatch, Director of the Division of Associated Health Professions in the Bureau of Health Manpower, expressed interest and invited me to visit his office to meet with him and his staff. I sent the report of Helen Ross's committee ahead and met with them in late September 1975. They noted the report was well done and were pleased some health educators were trying to put the profession in order.

Mr. Hatch's staff was familiar with the divisiveness rampant in the field a the time, between those in school health and those in community health. They said if they were to work with us they would have to have assurance that the field would work together. This was 1975. There was no money at the time, but I was told to keep in touch. I did that on a monthly basis for almost a year. In late August 1976, Mr. Hatch wrote that they could now see their way to working with health educators and invited me to come to his office to make some plans. Rather than going alone, I invited Dr. Lawrence Green, an able representative of the public health segment of the field, and Dr. Elena Sliepcevich, an equally able representative of the school health field, to join me. We met with Tom Hatch and his staff on October 5, 1976. Although there was no money to begin work immediately, they felt there would be before too long. They wanted and received assurances from us that our first step would be a conference which would assure the Bureau that the profession would work together.

In November 1977, the Division of Associated Health Professions funded a planning committee for a conference to deal with that issue. The committee included the presidents/chairpersons and/or their representatives of the eight organizations comprising the Coalition of National Health Education Organizations, all of which had an interest in some aspect of health education, a representative of the Bureau of Health Planning, and myself. This group formulated two questions for the Conference:

(1) What are the commonalties and differences in the function of health educators practicing in different settings;
and

(2) What are the commonalties and differences in the preparation of health educators?

What we needed to know was: Do those who practice health education in different settings feel they have enough in common to call themselves one profession; and, if they do, are they interested in a credentialing system for the profession? (DHEW-HRA-78-71)

Each of the eight organizations sent four representatives to the conference. These, plus the speakers, representatives of the federal government, and a few student observers made up the conferees. They dealt with the two questions referenced above using nominal group process. The answers were: "yes," we are one profession, and we do want a credentialing system.

All the conference papers offered insight into professional issues and credentialing issues. The concept of competency-based education and its counterpart criterion-referenced examinations, introduced by Dr. Robert Conant, staff member of the Division of Associated Health Professions, was new to most of us.

> ...criterion-referenced examination measure an individual's ability as it relates to some criterion, i.e., performance standard. The significance of an individual's score *is not dependent* on how he fares in terms of other examinees....(Conant, 1978)

This concept guided the process by which the credentialing system was developed and therefore the kind of examination which would be given for a credential. A similar process had been followed by many other professions.

BIRTH OF THE TASK FORCE

The conferees asked the Planning Committee to continue as a Task Force to develop a credentialing system for the health education profession. Therein was born the National Task Force on the Preparation and Practice of Health Educators. (See Conference Recommendations in Appendix D.)

The members of the Planning Committee for the February 1978 Bethesda Conference (which became the Task Force with a few exceptions) were appointed by their organization at the request of the Bureau of Associated Health Professions (Appendix C).

We do not have a record of the process used to select the representative for each organization. Perhaps they were selected by a vote of the executive committee or the board; perhaps it was the custom of the organization for the presidents to make that kind of appointment without reference to others. We do know that the Bureau of Associated Health Professions assumed that those present at the planning committee meeting were representing their organizations, however they may have been selected. And we do know that the organizations appointed a new member to the Task Force when their representative was unable to continue. At this juncture, Task Force members were considered representatives of their respective organizations. When the Task Force was incorporated in 1981, this changed, but in the beginning, that is how it was.

THE WORK BEGINS

The Task Force held its first meeting in Chicago on May 4 and 5, 1978, at the invitation of Dr. William Carlyon (American College Health Association representative). We met at the American Medical Association (free meeting space) and invited William Holland, staff member, Division of Associated Health Professions, to sit in on the meeting. We had no assurance, when we called the meeting, if or when there would be money to get the process started. Regardless, we had to get the ball rolling somehow and that was the purpose of the first meeting.

Mr. Holland told us it was likely there would be funding for a role definition contract soon, but he was not sure when. It was our fond hope that there would be a federal contract or grant for each of the steps in the credentialing process as defined at the First Bethesda Conference, i.e., Role Delineation and Verification, Education Resource Document, Self-Assessment Instruments, Continuing Competency Resource Materials, and Examination Development.

If funding became available, our dilemma was, who would apply for the contract and who would administer it? The Task Force had neither office nor staff. Several of the professional organizations had both, but the paranoia in he field at that time was such that if the project was administered by one organization it would be suspect of favoring that branch of the field. So, it was necessary to find a neutral group.

We asked Robert Johnson, President of the National Center for Health Education with offices in San Francisco, if the Center would administer the contract and allow the profession to provide the policy guidance; we didn't want to lose control of the contract or the process. Fortunately, this was agreeable to the National Center.

Role Delineation

In June of 1978, we received word that funding would be available if a contract was submitted by August of 1978. I wrote the contract that summer; it was awarded to the National Center in September. Events moved so quickly that we were unable to hire staff for the September "opening." So we proceeded without staff while the West Coast members of the Task Force (Helen Ross and Peter Cortese) interviewed potential staff. The federal contract required an advisory committee. The Task Force became the advisory committee with the addition of three members to fulfill federal requirements: (1) a member of another health profession, Elizabeth Lee, American Hospital Association; (2) a consumer representative, Reverend Robert McEwen, Council of Consumer Organizations; and (3) a representative of employers, Leonard Tritsch, Director of Health, Physical Education, and Recreation, Oregon. The contract also required that a working committee of professionals develop the role delineation in cooperation with the Advisory Committee and staff. The Advisory Committee selected the working committee on the basis of professional competence, representativeness of the field's work settings, and, to an extent possibly, geography. Our luck in recruiting some of the most able health educators in the

country for the role delineation working committee got us off on the right foot. (See Appendix C for list of members.)

In January 1979, Alan Henderson came on as Project Director and Deborah MacIntosh as his Assistant. Together, staff and working committee hammered out a definition of the role of the health education specialist. For the first time in the profession's history, specialists in school health education and in community health education faced each other across the table and learned that each was dealing with similar concepts, but using different terminology and, as well, applying them indifferent settings. This was the first step in the critical process of creating an understanding by all health education specialists that all had basic skills, concepts and theories in common. The work of the role delineation (role definition) committee is reported in DHS-HRA 80-84 (1980).

Viewing this report from a vantage point of 14 years, one is more aware than we were at the time of the theoretical and pragmatic correctness of the role definition. While the language has been simplified, the concepts have stood the test of time. This is not to say that they may not be expanded or new concepts added. But as these stand, they are essential for the preparation and practice of the health education specialists.

Role Verification and Refinement

The second phase of the project, role verification and refinement, the verification of the defined role, was funded by a sole source contract by the Division of Associated Health Professions. As in the delineation of the role, the staff worked with a working committee of health educators selected by the Advisory Committee using the same criteria used in he first phase. There was a five-month hiatus between the termination of the first contract in he Fall of 1979 and the awarding of the second contract in March 1980. The National Center for Health Education picked up the salaries of the project staff during this five-month period. This was a gift for which we shall forever be indebted to the National Center. We had no funds to support the staff. If the National Center had not come to our aid, we would have lost an able staff and would have had to start from scratch on the second contract. As shall be seen, the National Center was there for us more than once during the history of the project.

The federal contract required a survey of health education specialists to verify the defined role. Therein, we encountered a major problem, i.e., defining the universe of health educators. It was not definable. There was no universal list of the profession. The staff was very creative in identifying practicing health educators who fit the criteria for the survey. The survey results were encouraging in that they showed no difference in use of the competencies among practitioners in different practice settings. There was a difference in the degree to which competencies were used, as might be expected. For example, those in school health used community organization skills less than those in community health; nonetheless, community organization skills were used by school health educators. In the three years to follow, the Task Force took several other steps to further verify the role.

The federal contract also required that the verified role be defined at an academic level. Due to the various academic levels at which individuals entered the profession, with great reluctance, we defined it at the bachelor level. This decision haunted us for the next several years. It was changed to "entry level" in 1986.

It was clear long before the verification phase was completed that the possibility of a third contract from he Division of Associated Health Professions to develop the third phase of the credentialing process was very slim. The political scene was changing, the economy had taken a downturn, and the availability of federal funds on all fronts was scarce. In early correspondence with Dr. Monte Duval, President of the National Center for Health Education, it was clear that the Center could not carry the salaries of the project staff between contracts, should there even be another contract. So the Advisory Committee was alerted fairly early that it needed to look to other sources for money and make other plans to continue the credentialing project.

THE TASK FORCE CARRIES ON

When the Advisory Committee met in San Francisco in August of 1981 for the report of the verification phase, we knew there would not be federal funds for Phase Three. Therefore, prior to this meeting, in discussions among Advisory Committee members, we decided we would make an effort to go it alone. How? We were not sure. We thought we'd try to raise money from the profession and ask health educators in a geographical area to take on a specific task. If a group in the same area worked on a project, it would be far less expensive than traveling people from many sections of the country.

Therefore, at the August 1981 meeting in San Francisco, we made tentative plans to begin the third phase, the development of a curriculum framework. That was a very emotional meeting. Members of the Advisory Committee and the staff were upset at the possibility that all the good work which had been done in the past 2 years could be for naught. We were concerned about losing an able staff and staff were concerned about losing their jobs. This was a difficult environment in which to make long-term decisions. Nonetheless, there was agreement that: (a) we would try to continue; (b) we would try to raise money; (c) we had to incorporate the Task Force to be able to accept money. Further, Joan Wolle agreed to organize a committee in the Washington, D.C. area to conduct the first step in the development of a curriculum framework, a survey of professional preparation programs, to determine what was being taught.

As of the August 1981 meeting, the Advisory Committee, required by the federal contracts, was out of business. The Task Force was resurrected to carry on the work begun with the aid of the two federal contracts. We invited the three members of the Advisory Committee from outside the profession, required by the federal contract, to remain as Task Force members. All three accepted. They had become as involved and interested in the process as those of us who were members of the profession.

Despite disappointment at the loss of federal funds, the loss of a good staff

and the termination of our association with the able staff in the Division of Associated Health Professions, Task Force members rolled up their sleeves and went to work:

(a) The Task Force was incorporated in December 1981 in the State of Massachusetts. Incorporation changed the status of members so that official representation of an organization was no longer possible.

(b) Warren Schaller, Task Force treasurer, organized and carried out the fund raising effort in 1982: it netted $12,000.

(c) Joan Wolle's Committee in the Washington, D.C. area developed and carried out the survey of professional preparation programs (1981-82).

We were off and running!

Birmingham Conference

The survey of professional preparation programs was aided and abetted by the Birmingham Conference held in Birmingham, Alabama, in February 1981. The Conference was for academics, one branch of the profession with a vital interest in the defined role and the curriculum framework to be based on it. It offered them an opportunity to review and discuss the role and its potential impact on the field.

The Conference was funded by the Office of Health Information and Health Promotion in the Office of the Undersecretary for Health and by the Bureau of Health Education at the CDC. The Planning Committee was chaired by Warren Schaller, Ball State University. Conference papers, discussions, and recommendations are found in the Conference Proceedings (DHHS Publication No. 81-50171, 1981).

Funding agency personnel and the Task Force, represented by Drs. Schaller and Cortese, developed policy for attendance at the Conference, i.e., federal funds would pay half the expense of faculty attending from one university; conference planners would request that two faculty attend from one university; if only one attended, the same ratio of payment would apply.

Planning committee activities were funded by Dr. Warren Schaller at Ball State University and local arrangements, including a Task Force meeting after the Conference, were funded by the Dean of the School of Education at the University of Alabama at Birmingham, Dr. Millie Cowles. Dr. Mabel Robinson, a Task Force member and a member of the health education faculty at the University of Alabama at Birmingham, handled local arrangements. Two hundred sixty-nine (269) individuals attended the conference. Thirty-one (31) were practitioners including committee and Task Force members, staff of sponsoring agencies, and two non-health educator speakers. The remaining 238 academics represented 125 universities and colleges.

Many faculty attending the conference were pleased at the attempt to define and organize the profession. But an equal number were not. Some felt that the role definition was unnecessary, others felt it was not possible. One faculty member expressed the sentiments of many when he said that he would "go home, put this role on the shelf, and do nothing about it unless he was forced to."

A critical issue for the field and one which was to recur throughout the process was clear at the Birmingham Conference, i.e., the difference in philosophy and in the perception of the role of the health educator among faculty. The extremes of these differences were; the health educator as as specialists in health/disease issues (content) and the health educator as an expert in process with minimal knowledge about health/disease issues.

Early in 1982, the committee surveying the professional preparation programs polled the institutions which sent representatives to the Birmingham Conference to ask if they'd be willing to complete a survey of their professional preparation program for health educators related to the knowledge and skills in the defined role. Seventy-five of the possible 125 agreed. There was no uniformity in the curriculum of the 42 (56%) programs which completed the questionnaire. This was not surprising, but it was important to have it documented. This pattern of 75-125 responses of interest by professional preparation programs was to be repeated many times throughout the history of the project. Given that 300 programs are listed in the annual list of programs preparing health education specialists published for AAHE, this raises the question as to how many of these 300 really do prepare the professional health educator.

Curriculum

The next step in this process was the development of a curriculum framework based on the verified role. We called it a Curriculum Guide rather than a Framework at that time, which was a misnomer. Those familiar with curriculum development know that a guide provides specific guidelines from which a faculty develops a curriculum, whereas a framework is simply that: it is a frame of reference around which a curriculum can be developed by those with that expertise. It does not tell a faculty what to teach or how to teach it. It simply tells them what the students should know when they have completed the program of studies.

Curriculum Guide

The development of a curriculum framework requires intensive work by one or two people. Dr. Duval, President of the National Center for Health Education, raised $6,000 for Task Force activities from the Esmark Foundation in Chicago. This allowed us to pay expenses for writing the guide and to give the writers a small "reward" for their labor. It was, however, not enough money to fund a meeting of a working committee so we could continue the practice of using a committee of health educators to work with staff for each phase of the credentialing process. As happened so many times in the history of this project, someone found the money to fund such a meeting. In this case, it was Dr. Warren Schaller. He gathered a group from the Midwest which met at Ball State University in December 1982 (list of committee, Appendix C). We recruited Dr. Betty Matthews, University of Washington, and Dr. Herbert Jones, Ball State University, to cooperate on writing the Guide. The function of the committee was to provide the writers with assistance and guidelines.

No one at this meeting in December 1982 had experience in developing a curriculum guide consistent with competency-based education. We drew on the work of the faculty of East Carolina University, Greenville, North Carolina, who had developed this kind of curriculum (Garton et al., 1984). That faculty's experience was invaluable to the Committee as it worked out guidelines for the writers.

Having developed the guidelines, each committee member selected a few concepts in the verified role and tried their hand at following the suggested guidelines in translating them into the required format. Having done this, the writers were left to go to work.

A problem arose fairly early in this phase. The writers submitted to me, as Chairman of the Task Force, samples of what they were doing. I commented on my sense of the appropriateness of these. When the Task Force met in March 1983 in Washington, D.C., I gave the members blind samples of the work of both writers and asked for review and comment. The two samples were very different in style. The Task Force selected the style they believed was most appropriate for meeting our needs. I conveyed this to both writers and requested that they continue to develop the curriculum guide in the pattern acceptable to the Task Force.

We had been working on funding the printing of the Guide and found the Office of Disease Prevention and Health Promotion in the Office of the Undersecretary for Health interested in buying 500 copies to distribute to the schools and universities on its mailing list, provided these copies could be in the mail by the end of September.

When the writers submitted their final version of the Guide, again, the two styles were very different. It was immediately clear that the style of the Guide had to be consistent. So, the material had to be reorganized. This was another few weeks work. We received the material from the writers in June. Dr. Marion pollock had agreed to edit it. Once edited, it had to be retyped, printed, and in the mail by the deadline. This gave no time for major revisions. It was my sense, in consultation with the Vice-Chairman, that we had no choice but to go with the version which we believed was acceptable. Needless to say, this caused the Task Force more than a little difficulty, which we did foresee. What we did not foresee was the divisiveness which this would create in the field—divisiveness which mitigated over time, but in 1983 it was so destructive that it had to be confronted. This took the time and energy of Task Force members away from professional issues which required our attention.

A user survey, to which 81 responded, was included with the Guide. Eighty percent found it readable and the format and the material presented useful. The strength most often mentioned was the availability, for the first time, of a definition and clarification of the role—offering, as they said, a common base of competencies which all could follow. It was seen as a very positive effort. The chief weakness was perceived to be requiring too much at the undergraduate level. School health professionals also felt it was not sufficiently oriented to their branch of the field.

Regional Workshops

It was clear that the Guide needed extensive pretesting. It was published as a draft—certainly intended as a draft. We felt the most effective way to pretest was one-to-one contact with the faculty who would be using it. Regional workshops seemed a good way to do this. Through the efforts of the Vice-Chairman, Dr. Peter Cortese, we received a grant of $12,000 from the Centers for Disease Control to hold a training workshop in Chicago in June of 1984 for 12 faculty. These faculty were selected from 50 applicants who indicated on the user survey that they would be interested in attending a training institute in order to run a workshop in their section of the country. These 12 were selected on the basis of geographic region, experience with workshops, familiarity with the Curriculum Guide and with the project. It was unfortunate that we had money for so few. The training workshop was planned by a West Coast group co-chaired by Drs. Peter Cortese and Helen Ross. Drs. Marion pollock and Nick Weddle were members of the planning committee.

This training workshop offers a good example of piecing together resources, the Task Force's survival technique—i.e., an excellent planning committee which provided the needed professional input; an excellent working environment due to the meeting space, and luncheons provided by Dr. William Carlyon at AMA; CDC's money paid for air transport and hotel rooms; the conferees bought their own dinners.

The 12 who attended the workshop began to plan local workshops immediately on returning home. They raised money from local organizations, e.g., local chapters of professional societies and voluntary agencies; and all charged small registration fees to cover expenses. The final tally on local workshops was: 186 faculty from 37 states, representing 86 different schools attended 11 workshops. Only one training workshop attendee was unable to follow through with plans for a local workshop.

The reports of the regional workshops identified many of the problems noted at the Birmingham Conference; i.e., a wide difference in the perception of the role of the health educator as well as the strong adherence to the notion that faculty were either content experts or process experts and never the twain shall meet. Some faculty clearly did not agree with the Task Force position that the health educator's basic discipline was education; i.e., the learning/change process as applied to health and disease issues. Some believed the curriculum was asking too much of the baccalaureate level. Others did not agree with this and felt the entry level preparation of the health education specialist should be at the master's level. In addition, the lack of content, i.e., health topics in the Guide, became an issue with some as the project progressed.

Along with this feedback from the workshops, we received feedback from national and local meetings of professional associations. Every national meeting from the beginning of the project had something on the program about credentialing. Sometimes it was a poster session and sometimes it was a panel discussion. The feedback from these sources was more from the practitioner than the academician, a sector of the field from which we needed to hear.

Some individuals who received the Curriculum Guide and attended neither the workshops nor professional meetings sent us their views.

Curriculum Framework

All this feedback provided further verification and refinement of the role. It also demanded that the Guide be revised. Dr. Marion pollock agreed to do this. We wanted a Framework, not a guide. As Marion began to consider the revision, she raised a number of questions on what could be changed based on the feedback from the field. Those members of the Task Force who lived in the D.C. area, Anna Skiff, and I met in D.C. to review the questions and provide her with answers. She then submitted an outline for the curriculum framework which the Task Force reviewed and responded to at its meeting in Washington in May of 1985. The revised Curriculum Framework was completed in July of 1985. The Office of Disease Prevention and Health Promotion agreed to buy 1,000 copies, as they had before. Unfortunately, due to budget cuts, we learned the day the revised edition was delivered by the printer that the Office of Health Information and Promotion (OHIP) could not pay this bill. We were in trouble! Our only source of money was the sale of the Framework. This could take a couple of years. Would the printer wait? Fortunately, a friend of the Task Force, who asked to remain anonymous, heard of our dilemma and sent a check for $3,900. We shall be forever grateful to that friend who bailed us out of this difficult and potentially embarrassing situation.

Following the publication of the Curriculum Framework, the Task Force discussed next steps. Self-assessment/ continuing education was the next issue on the list in the credentialing process. That clearly needed attention. But, we also felt it was time to go back to the profession and ask whether it wished the Task Force to continue to develop a credentialing system. We began to work on both issues at about the same time. I'll deal with self-assessment/continuing education resource material first.

Self Assessment/Continuing Education

Continuing education and self-assessment instruments were discussed by the Task Force as early as 1981, because it was recognized that continuing education and self-assessment would reach the grass roots. Practitioners and academicians who were not in leadership roles in professional organizations did not get to national meetings, or didn't always read newsletters or journals, could be acquainted with Task Force efforts to develop a credentialing system for the profession through self-assessment/continuing education materials. Our efforts early-on to do something about continuing education always floundered: lack of money, demands of higher priority items—e.g., publishing the Curriculum Framework, finding the right person to take on the project, and dealing with problems. We considered many possibilities in 1982, 1983, 1984, and 1985, but none of them materialized. It was frustrating.

It was not until 1986 that we were able to get self-assessment/continuing

education off the ground. This happened as a result of a chance conversation I had with Clarence Pearson at Metropolitan Life. He mentioned that the Metropolitan Life Foundation had funds for continuing education for teachers. Anna Skiff and I visited the staff of the Foundation to learn about their priorities. As a result of that meeting, we submitted a proposal to develop a continuing education model for teachers of school health education. Although our objective was broader than continuing education for teachers in schools, a model for this group could be adjusted for the continuing education of the health education specialist working in other settings.

This project was funded in December of 1986. A committee in the Midwest, chaired by Dr. Wanda Jubb, Director of Health Education, Michigan State Department of Education, developed the model which was pretested by faculty who prepared teachers of school health at a meeting in Washington, D.C. in March 1987. This pretest raised once again many of the issues which came up in the regional workshops for the Curriculum Guide, including the issue of content and the disparity among faculty views of the function of health education specialists regardless of the setting in which they might work. For example, one faculty person saw no need for a health education specialist doing a needs assessment in a school setting. On the other hand, there were those faculty who were in total agreement with the concept of generic competencies for the entry-level health educator and saw them as a great boon to the promotion of the health education profession. The draft document entitled "Continuing Professional Development for Health Educators," which Wanda and her committee developed, lent itself not only to continuing education but to self-assessment as well. Individuals could use some sections of the document to assess their skills and knowledge in the practice of health education.

As a result of the workshop and a review of the document by the Task Force and others, suggestions were made for some revisions. These revisions were made, but to our knowledge the document was not widely distributed. This was partly because the issue of the development of the commission (NCHEC) and how it would be structured and funded was more pressing at that time.

Checking with the Profession (Second Bethesda Conference)

The Second Bethesda Conference held in February 1986 in Bethesda, Maryland, exactly 8 years after the First Bethesda Conference, was the vehicle the Task Force used to ask the profession whether they wished to continue with the development of a credentialing system and, if so, what kind of a system did the profession want? The Proceedings of the Conference, sponsored by the National Center for Health Education and the National Task Force on the Preparation and Practice of Health Educators, Inc., give the detailed answers to these questions (NCHE, NTFP, and PHE, Inc., 1986).

In planning the Conference, two basic questions were: Who was to be invited? and How was it to be paid for? As to whom to invite, clearly the leadership of professional associations, those in positions to influence hiring health educators, and anyone in the field who wished to come was welcome.

Initially, several federal agencies with an interest in health education agreed to support a certain number of participants: the Bureau of Health Education, CDC, the National Cancer Institute, the National Institutes of Health—Division of Lung Disease, and the National Institutes of Health—the Heart, Lung, and Blood Institute. Because of budget cuts, much of this support eroded by Conference time. The Centers for Disease Control did support the attendance of the members of the Coalition of National Health Education Organizations and the National Cancer Institute did support 20 other individuals. Everyone else attending the conference, including the Task Force members, paid their own way. We charged a registration fee of $50, which helped with expenses for materials, speakers, refreshments for breaks, luncheons, etc.

Since we didn't have funds for individual invitations, we contacted professional organizations and asked that they notify their membership, by any means they had, that the Conference was to be held and that anyone who wished to come was welcome to attend, at their own expense. Preregistration was necessary, since materials would be sent in advance to those attending. Further, a letter of invitation was sent to every academic department which claimed to have a preparation program for professional health educators.

Professional associations sent lists of their leadership whom they thought should receive an individual invitation, and a list of influential people in the federal government was also submitted. All of these did receive individual invitations.

Ninety-nine individuals attended the conference. They were divided into five groups and each group responded to the following questions using nominal group process:

(a) Do you want credentialing for the individual? If yes, what form should credentialing take, and what is the rationale for your answer?
(b) Do you want credentialing for a preparation program for the health education specialist? If yes, what form should this credentialing take and what is the rationale for your answer?
(c) What should the minimum requirements be for credentialing health education specialists?
(d) What would you accept as an adequate assessment of the competency of the individual health education specialist?
(e) In your judgement, what are the next steps for quality assurance for health education services?
(f) What resources are needed to carry out each step? Where do we find the resources to carry out each step in the plan?
(g) Identify management services required to implement a credentialing plan and recommend the policy-making body needed to guide the management services.

Four of the five groups were in agreement: they wanted a credentialing system for the individual; the method should be certification; they wanted some form of credentialing for the preparation programs; they wanted the Task Force to continue to develop a credentialing system. They requested the Task Force do so by 1988. The Task Force did accommodate this request.

The comments of each of the five working groups are reported in the

Conference Proceedings as recorded on the newsprint for each session (NCHE, NTFP, PHE, Inc., 1986). A review of these comments makes clear the consensus of the four groups. The group which did not agree with the other four questioned the conference recommendations. Therefore, after the Conference, a mail ballot was sent to all attendees. They were asked to sign the return envelopes so names could be checked against the Conference attendance list. The ballot asked the same questions about credentialing which were asked at the Conference. Of the 99 registered at the Conference, 87 responded to the mail ballot in exactly the same way they had at the Conference.

One of the most disturbing notes at this Conference was the clear statement from employers of health educators that most health educators were not prepared to do the work expected of them at entry level. This was not news, but we had never received the message quite as clearly before. One speaker on the employers' panel from a large metropolitan area, with a degree in health education, indicated that she hired very few with degrees in health education because they did not know how to do anything in the field. One of the employers of a number of health educators said if we don't clean up our professional preparation programs, we might as well throw in the sponge; if we don't do the job, others were going to do it for us. He mentioned the American Psychological Association's ability to respond to the new health promotion craze by getting several psychology departments in universities to develop a curriculum in health psychology. Since we have neither one professional organization nor any organization for preparation programs, we have no mechanism for dealing with change that occurs rapidly or slowly.

The Plan of Action

Following the Second Bethesda Conference, the Task Force reviewed the proceedings and developed a plan of action based on the recommendations of the five working groups. This plan received wide distribution, including professional associations, both local and national, academic institutions, and the list of leaders we had. We requested feedback from individuals and groups on the plan and received many useful comments and ideas. The Plan was the basis of the agenda for Task Force meetings from that time until the commission was organized in Palo Alto, California in 1988. Credit for holding us to this agenda goes to Dr. Alyson Taub, Secretary of the Task Force.

As we moved through the agenda driven by the Second Bethesda Conference Plan, known as The Plan, there were four major issues which required careful thought. These were: (a) how to set up a certification system for the individual health education specialist; (b) accreditation of academic programs (although a health education credentialing organization would not accredit academic programs, it was essential that existing accreditation bodies be aware of our efforts and coordinate with us to the extent possible); (c) how would a credentialing organization be structured; and (d) how funded?

Our first step was to define the mission of the credentialing organization and then identify the component parts. This accomplished, the Task Force thought through and set up the structure of what is now the National Commission for

Health Education Credentialing. Dr. Becky Smith was a major contributor to these discussions. The certification process and linking up with existing accreditation programs, however, required a different approach.

Certification of the Individual

Dr. William Cissell, Tennessee State University, chaired and organized a committee of health educators in Tennessee and Alabama to examine the individual credentialing practices of other professions. Among the professional groups the committee talked with were social workers. There appeared to be enough in common between social workers and health educators to warrant further investigation of their individual credentialing system. Anna Skiff worked with the staff of social work system to identify the elements of that system which would fit our needs. There also was a need to identify programs which offered a major in health education. We surveyed the programs on the list published annually by the Association for the Advancement of Health Education as health education programs. It was a simple survey asking whether they offered a major in health education. For those who answered "yes" (167), we planned a second survey to determine what constituted a major. Because of lack of funds, the second survey was not done.

The work on certification came together at this time with our continued search for funds to set up a credentialing system. Task Force fund raising efforts were extensive, but unproductive. Our luck changed one day when Dr. Becky Smith and I met with the President of the Professional Examination Service, Dr. Craig Schon.

The Professional Examination Service develops certification and licensure examinations for a number of professional and technical groups. The combination of the organization's expertise in examination preparation and its ability to provide start-up funds for such a purpose was, to say the least, an answer to our prayers.

The history of our relationship with PES goes back to the very beginning of this effort. It was the President of the Professional Examination Service, Dr. Lillian Terris, who provided me in 1976 with the direction which eventually led to federal contracts to define and verify the role. In 1982, I received an invitation from the President of PES, Craig Schon, to speak to their Board about the work which the health education specialist had done towards developing a credentialing system. This invitation came about because the President and the Vice-President of the Board were professional health educators. I found the board interested and many members surprised to know that health educators were getting their act together. The follow-up from the presentation to the PES Board was an invitation by Dr. Schon to help us find funds to continue to develop the credentialing process. To back up that offer, he gave me the services of a PES staff member who was to work with me in developing a grant proposal. Unfortunately, due to personal and family illness, the staff person was unable to be helpful. We invited Dr. Schon to give a paper at the Second Bethesda Conference. At that time, he again expressed interest in our work and was disappointed to learn that PES's previous attempt to be helpful had not worked out.

And, once again, he asked to be kept informed of our activities.

At one of our innumerable discussions about funding, Dr. Becky Smith wondered aloud if some organization might be willing to put up the funds to get us started on condition that we pay back when money came in from certification examinations. We wondered if PES would do this and decided it would do no harm to ask.

Dr. Smith and I met with Craig Schon and told him of our need. He offered to help. We didn't have to ask! PES would put up the money to get us started and had no concern about our ability to return their investment.

This was the best break the Task Force had in 8 years! It gave us the potential of working with a professional group which understood certification and how examinations were developed, and the need for other elements of a credentialing system as well. For the first time, we could see light at the end of the tunnel. What a relief!

When we brought this good news back to the Task Force, we agreed that we should investigate the possibility of getting a similar proposal from other organizations so we would have a choice. Accordingly, Alyson Taub and Anna Skiff met with staff of the Educational Testing Service (ETS). ETS was willing to make the same arrangement as PES. They did, however, want to redo some of the steps we had already completed to set up a credentialing system. The Task Force decided to go with PES because of their familiarity with our work, their acceptance of our efforts, and our long, pleasant relationship.

All of the above occurred in the Spring of 1987. I retired in June of 1987 from my full-time work and from the Task Force. It was time for me to leave the latter. I no longer had the support services (i.e., secretary, xerox machine, telephone, mailing service, etc., which I had been able to use for 9 years for Task Force activity). So, I did not participate in the staff work done by Anna Skiff and Alyson Taub with the PES staff in setting up all the details of the grandparenting phase and the first certification examination. I did, however, participate in Task Force discussions regarding the issues related to this phase since I met with Task Force until the Commission was officially organized in June of 1988.

Accreditation

The Task Force's mission was to organize a credentialing system including accreditation of academic programs and certification of the individual. As mentioned above, a great deal of effort centered on the certification of the individual. Our activities related to academic accreditation were of a different kind.

Our concern about academic accreditation was expressed very early in our deliberations. A June 1982 memo to the Task Force mentions the need to "talk about credentialing," i.e., the need to talk with the accrediting agencies dealing with colleges and universities in which health education preparation programs were located and agencies accrediting or approving preparation programs as against accrediting a university. These included the National Commission for the Accreditation of Teacher Education (NCATE), the Council on Education for Public Health (CEPH), and the Society for Public Health Education (SOPHE). The purpose of the "talks" was to learn what was being done, what needed to be

done, and how our efforts could be coordinated with those of the accrediting agencies.

We learned that many preparation programs at both the undergraduate and the graduate level were located in universities and colleges which were not accredited by either CEPH nor NCATE; nor had the undergraduate programs requested "approval" by SOPHE. There were (and are) huge gaps and great discrepancies in the accreditation/approval process. I have dealt with these discrepancies elsewhere (Cleary, 1986).

Since the Task Force was concerned with a total credentialing system, we entered into discussions and negotiations about academic accreditation. It would have been helpful to have had an organized group of health education professors or chairs of health education departments to work with, but there was not one, and attempts to organize one had not succeeded up to that time.

At the Birmingham Conference, the idea of a formal organization of professors of health education, but especially of the chairs of departments, was put forth. It has been the practice for the chairs to meet at the AAHE annual meeting and for the professors of public health education to meet at the SOPHE annual meeting. In these sessions, ideas and information are exchanged, but neither group was a formal organization which could speak for the health education academic community.

In 1985, Glenn Gilbert, University of Maryland, proposed organizing a council of chairs of health education programs. Unfortunately, he tied to this idea to a registration of these programs. Because of this, the Task Force was concerned about the potential of two credentialing bodies within one small profession. A good deal of Task Force time and energy was spent writing and meeting with the chairs of academic programs to discuss the organization of the council and the potential registry. Finally, the notion of the registry was given up in 1987 because of the great variety of faculty, administrative arrangements, courses, and philosophies of the various preparation programs. No common ground could be found on which to base a credential. That fact raised a red flag for me about professional preparation programs and it still does.

Institutional accreditation frequently is not designed to judge the quality of individual academic programs. It does judge the quality of the college or university. However, most national accrediting bodies will accept standards set forth by a profession and apply them in their accreditation process to academic programs related to that profession if the profession so requests. Therefore, the Task Force approached both NCATE and CEPH about accreditation of institutions in which there were programs preparing health education specialists. NCATE accepted the skills and competencies set forth in the Curriculum Framework as a part of their accreditation process for programs preparing school health educators since NCATE accredits only teacher education units as a whole. CEPH, which accredits schools of public health and some public health related programs outside schools of public health, looked at these skills and competencies as ones that should be required of those entering a master level program.

The Task Force approached the SOPHE Board in 1984 to ask whether the excellent document SOPHE had developed in the seventies, for the approval of undergraduate programs in Community Health Education, could be adjusted to

accommodate the concept of the generic entry level health educator and include the competencies and skills in the curriculum framework rather than the courses listed in the document. We also asked whether SOPHE would consider making the SOPHE undergraduate approval process a profession-wide approval process, i.e., a SOPHE/AAHE process. This would, of course, require approval by the AAHE and SOPHE Boards.

It took about 3 years to get all of this accomplished. Our 1984 request got lost on someone's desk, so in 1986 we again approached the SOPHE President and the process began to move. Two volunteers (James Cory and Nicholas Galli) recruited by Anna Skiff, did the detailed work of adjusting the language of the document. The AAHE office took on the arduous task of retyping it. The AAHE Board approved the document and the concept of a profession-wide undergraduate approval process as did the SOPHE Board. In 1987, a joint committee was appointed by the presidents of SOPHE and AAHE and the profession-wide undergraduate approval process was under way.

We mentioned above that there were gaps and disparities in the accreditation process and that we had treated these in detail elsewhere. It is worth mentioning a few of the disparities here. CEPH accredits schools of public health but, at the request of more than one profession, has assumed responsibility for the accreditation of public health programs in non-schools of public health. It does accredit master programs in community health education. This is programmatic as opposed to institutional accreditation, both of which are at the master levels. It is clear that health education preparation programs outside schools of public health accredited by CEPH receive a much more rigorous review than those in schools of public health. In institutional accreditation, CEPH may and does identify problems with specific programs, but a school would not lose its accreditation if one program was not up to par, whereas it is possible that the same program outside a school of public health would not be accredited.

NCATE accredits only schools of education; *a program preparing community health educators in the same institution as a school health program would not benefit from NCATE's use of the competencies and skills in examining undergraduate programs*. That community health program would have to request approval from the SOPHE/AAHE undergraduate approval process; an additional expense for the university. Often, faculty who request programmatic accreditation have a hard sell with some administrators because of the cost; in some cases, it is almost as expensive as accrediting the entire university. Finally, school health education programs at the master level have no professional input in the accreditation process.

Accreditation of professional preparation programs for the health education specialists has been, and is, a badly made jigsaw puzzle. The variety of accrediting agencies would not be a problem if the profession agreed on standards for academic programs such as faculty/student ratio, faculty background, library facilities, certain requirements for the curriculum, e.g., field work, something similar to what the social workers have done. With no agreement on these issues, we cannot expect the accrediting bodies to take us too seriously.

Professional preparation is the single most troubling issue with which the profession must deal. The accrediting mishmash mirrors this basic issue. I

received a letter in 1984 which describes some of the problems related to undergraduate preparation. It reads:

> We probably have more professional preparation programs than there are jobs available. Also, the average faculty size (true of health education faculty) is less than two per program. So, the training is being done in programs which are understaffed. We are loading the market with people who have been given the impression that they are prepared when actually they are not. Perhaps a solution is retrenchment to cut down the number of programs. The role delineation project is the step in the right direction. This should create more productive programs. At this time, there is an excess of 300 places with school health degrees. In my opinion, there should be less than 100.

ADMINISTRATION

THE TASK FORCE

We stated above that the Task Force, with a few exceptions, was the planning committee for the First Bethesda Conference, and that members represented one of the eight national organizations with an interest in health education until the Task Force was incorporated in 1981. The membership remained intact until 1986 with two exceptions: Mabel Robinson died in 1983, and Warren Schaller resigned in 1983; they were replaced by Wanda Jubb and Becky Smith.

Task Force members functioned both as staff and as policy makers, and part-time staff at that. It takes time for any staff to become familiar with their job, their co-workers, and the various publics with whom they will work. This is more difficult for part-time staff and more so when that staff is spread all over the country and able to meet with co-workers only two to three times a year. So, our "staffing" situation was tenuous at best. The support we gained from the continuity of membership and our growing familiarity with issues, and knowledge of one another's strengths and weaknesses, played a key role in the achievement of our goal. The fact that the same group worked on a task for the history of the development of the task is not uncommon. That is, after all, the function of a task force.

In 1985, there was pressure from some health educators to rotate the membership and questions were raised about the process by which one became a member of the Task Force.

By 1986, we felt it was safe to begin to take on new members; we were within reach of our goal. Up to that time, breaking up the team would have been detrimental to the goal. The criteria for selection of new members, and it was a selection by other Task Force members, were: (1) demonstrated interest in the credentialing process; (2) worked on some phase of the process; (3) committed to credentialing; (4) had or could make time to do staff work; (5) compatible with Task Force members; and (6) had a willingness to pay their own way to meetings if that was necessary. This was necessary, at least partially, for almost all meetings. We saw it as our responsibility to identify and invite individuals to join the Task Force whom we believed would work with us to complete the task we were assigned.

The Task Force met every year at the annual meetings of AAHE and SOPHE/APHA. All members did not attend both meetings, but whoever attended did meet formally. It was a way to get some business done at no additional cost. While this did work for some of our business, squeezing another meeting into an already too full calendar at national professional meetings is not the most satisfactory way to make clear decisions. We did meet at least one other time during the year and sometimes twice, depending on the issues and whether we could find funding. Some Task Force members were able to fund a meeting from the budget of their departments. Some where able to offer free meeting space and inexpensive meals. We piggybacked on a national conference and did use Task Force funds for airfare and hotels occasionally. Somehow or other we man-

aged to get together. The meetings were always productive. The machinery was well oiled. In the 9 years I was with the Task Force, we learned how to work together to get the most out of our weekend meetings. It is too bad that we did not think to videotape some of the sessions as they were classic examples of group process and decision-making.

There is no way I can convey the intensity of these meetings: our disappointment at the blind alleys we pursued; our joy over the productive avenues we traveled; the number of times we thought we could not continue and then we did. By chance, we had gathered a group of competent professionals who cared and believed the goal was worth the struggle; and a struggle it was.

FINANCES

In describing Task Force activities from 1981, when the federal grants terminated, to 1987 when I retired, I've mentioned the fund raising effort with the profession in 1982 and grant funds received. The total from these and other sources was about $66,500.

- $12,000 was raised from the profession; $10,239.50 of this came from 506 individuals and the remaining from professional organizations. In addition, some professional organizations sent us checks from time to time. The total from this source was about $2,500.
- $6,000 from the Esmark Foundation used for the Curriculum Guide
- $12,000 from CDC to support the workshops on the Curriculum Guide
- $3,000 from sale of the Curriculum Guide/Framework
- $29,000 from Metropolitan Life Foundation for developing continuing education materials and self-assessments
- $1,937 interest (treasurer invested free cash in short term notes)

All of these funds, as you will note, were earmarked except those from the profession, the income from the sale of the Curriculum, and the interest. These were used to raise other funds and to cover incidental expenses for all the projects for which there were no other funds. The policy regarding these monies was: "Don't spend it if there is any other way to pay for it, and work very hard to find another way to pay for it." Under that policy, all of that money was spent by 1986.

Special projects were funded directly, i.e., we did not have access to the cash. The Birmingham Conference was funded by the Office of Health Information and Health Promotion in the Office of the Under Secretary for Health, the Bureau of Health Education at the Centers for Disease Control and the universities which sent faculty to the Conference. The purchase of a large number of Curriculum Guides by the Office of Health Information and Health Promotion made it possible to pay the printer's bill and we cannot forget the friend of the Task Force who paid the printer's bill of $3,900 for the revised

Guide, the *Curriculum Framework*.

All members of the Task Force did staff work on the various projects, and each received the necessary support services from their organizations, e.g., mail, phone, etc. I was especially fortunate to be working in a setting where the policy about the availability of these services for faculty was very liberal.

Add to all of this the free rent and support services donated by the National Center for Health Education for our office in New York City; and the staffing of that office by so able a health education specialist as Anna Skiff, and it comes to a considerable sum. I'd guess at one and a half million dollars, plus the two federal contracts (about $500,000) to be the actual cost of setting up the credentialing system.

The fact that we had only $66,500 in actual cash does not mean that we didn't try to get more. Fund raising was an ongoing Task Force activity and concern. We spent two frustrating years working with the Kellogg Foundation on a grant to fund self-assessment and continuing education. Two Task Force members, Dr. Peter Cortese and I, and four non-Task Force members, Drs. Beverly Ware and Lawrence Green, Mr. Chester Bradley and Mr. Clarence Pearson, met with the Kellogg staff on December 6, 1983. (The funding of this meeting with Kellogg offers an example of Task Force "luck". When the meeting was planned, the expenses were to come from Task Force funds; after the meeting, I had a call telling me these could be paid from another source.)

We were encouraged to submit a proposal. It was turned down. Two years of work had come to naught. It was not until after the Second Bethesda Conference when the need for funds to get the credentialing system up and running was acute that we approached foundations again.

We had help with this task:

(a) A health educator, working for a large national organization, loaned the Task Force the services of the organization's fund raiser for a short time.
(b) Flora Bloom, then a graduate student at New York University, poured through the Foundation directory for us and identified a number of foundations with an interest in health issues.
(c) Anna Skiff and I visited with some friends who were working for foundations for advice and counsel.

We culled through all the information we had, and zeroed in on six large foundations with an interest in health issues. Cover letters and statements were prepared and reviewed by the Task Force members and rewritten and reviewed and rewritten again and again. Before sending the letters, a Task Force member talked with either a staff member or a board member, preferably the president of the Foundation; six letters went out and six rejections were received. I was not surprised. My phone conversations were not encouraging. I found that the interests of most of the foundations were programmatic, e.g., teenage pregnancy, the aging, substance abuse. I found little interest in broad-based issues such as the quality of the staff for the programs in which they were interested. It was also clear to me in these conversations that there was little interest in helping a profession get its house in order. The impression I received was that was the profession's problem; it should support that effort itself. And indeed, that is what

we have done.

Meanwhile, we were constantly on the lookout for federal funds. Peter Cortese and I spent a great deal of time working on proposals for various phases of the project for funding by the Bureau of Health Education at the Centers for Disease Control. Initial conversations with the Director were encouraging. We had extensive discussions and correspondence with him and visited with him and his staff in Atlanta. But, everything kept falling through the cracks; nothing quite worked out. It was my sense in our last conversation with the Director and his assistant that they felt we were spinning our wheels and that the project would go nowhere. Subsequent events proved this to be the case. They were not alone in their perception of the project.

VOLUNTEERS AND OFFICE SPACE

We mentioned in the preface that NCHEC would not have been possible had it not been for the thousands of hours of service contributed by the profession. All of the substantive work completed between 1981 and 1991, when the Commission hired staff, was the work of volunteers.

We actively recruited help, as mentioned above, through the user survey with the Curriculum Guide, at the Second Bethesda Conference and by word of mouth. Many offered their services. We were not always able to use everyone who volunteered, because they were not located where we needed help at a given time. We always asked that they help by spreading the word about the project among their colleagues.

Volunteering took many forms: making phone calls, stuffing envelopes, serving on committees, drafting letters, reviewing proposals. One form which was different from the rest was the offer of "a desk" in May of 1983 by Clarence Pearson, then the President of the National Center for Health Education, now with offices in New York City.

We desperately needed a base from which to operate. We had neither an address nor a phone number. It was not possible for anyone to get information about Task Force activities unless they were acquainted with one of the members. It is difficult to do business under these circumstances. I talked with Clarence Pearson about our need and he came through for us. At the same time, I talked with Anna Skiff about being the "volunteer" staff for the office one day a week. She agreed and moved in in September 1983.

Our negotiations with the National Center for the "desk" included a small monthly payment ($50.00) for the use of the phone and mail service. We also agreed to pay Anna's transportation costs into NYC; a Task Force member picked up the latter bill from his budget for four months and Anna never billed us after that. The National Center did not bill us either. Our poverty was all too evident.

The availability of the office and of the services of so able a health education specialist as Anna Skiff were two "lucky breaks" for the credentialing effort, and they arrived just in time. The Curriculum Guide was in the mail in September 1983. People had questions; they needed to reach us. Anna responded to all types of requests by phone, mail, and sometimes in person. She worked

with the Task Force on all projects, doing what was needed and always contributing substantively. Some weeks, her one day stretched to two or three.

Anna's value to the Task Force cannot be estimated. Her long and varied experience as a practitioner, her wide acquaintance in the field, and the enormous respect in which her professional acumen and personal integrity were held were tremendous assets to the credentialing process.

PARALLEL AND RELATED ACTIVITIES

While the Task Force was busy developing a credentialing system, others were busy with related activities, many of which enhanced the Task Force efforts.

(a) Dr. Sue Beall, College of Education, Texas A&M University, and her colleagues developed a pre-internship examination for fourth-year students based on the Curriculum Framework. They did the initial work on their own and received a grant from the Metropolitan Life Foundation to establish the content validity and technical validity of the items and to revise, produce, and field test the instrument. This instrument has the potential for improving professional preparation.

(b) The Education Testing Service developed a national examination for teacher certification on knowledge of specific subjects, e.g., English, mathematics, etc. Many who worked with the Task Force were involved in writing the items for the health education segment of this examination. This activity was supportive of our efforts in that it dealt with the content issue.

(c) Dr. Lynn Waishwell, Illinois State University, Normal, using the competencies identified in the Framework, developed an undergraduate advising tool whereby a faculty member could review a student's skills and identify those with which students felt competent and those with which they did not.

(d) The faculty at California State University, Long Beach, tested their curriculum against the Framework, utilizing a matrix system. In this way, they were able to identify strengths and weaknesses in their programs.

(e) The health educators in Florida organized a credentialing system, a registry. They developed an examination, both written and oral, to test competencies.

(f) In 1984, the Minnesota Chapter of SOPHE developed a Board of Registry which worked for over a year to develop an assessment tool (based on the Curriculum Framework) to measure the competency of the health educator. The applicants for listing on the Minnesota registry must demonstrate competency in seven areas of expertise.

(g) In 1984, the Alabama health educators organized the Health Education Association of Alabama and developed a registry for health educators.

(h) The New Jersey SOPHE Chapter used the competencies in the Curriculum Framework as the basis for revising a state document which proposed health education standards for public health activities.

(i) In Michigan, both Michigan SOPHE and the Michigan Society for Hospital Educators and Trainers developed a "hospital-wide patient education coordinator competency," very similar to those developed by the Task Force.

(j) Arthur Koski (1978), on his sabbatical from Oregon State University, did a study of the programs claiming to prepare health education specialists. He described curriculum, faculty, and setting. This gave the Task Force, very early in its deliberation, insight into the great diversity among programs.

(k) In 1986, the publication of the Carnegie Report on undergraduate education and on public school education supported the Task Force's concern for the quality of undergraduate preparation of the health education specialist. The report had little to say that was positive. It confirmed our observation and the reports received in a variety of ways that undergraduate education needed considerable upgrading before it could produce qualified professionals in any branch of education.

(l) An article in the February 20, 1987, issue of *Science* reported on teacher certification which the National Science Teachers Association had started similar to the one mentioned above that ETS was developing for teachers of all subject matter. These science teachers' activity was, "in response to accumulating evidence that science teachers in many American schools are inadequately prepared. It is aimed at establishing high standards for training and employment for science teachers."

(m) In an article in the April 28, 1985, *New York Times*, it is reported that Albert Schanker, President of the American Federation of Teachers, an AFL/CIO union, said that, "collective bargaining has been a good mechanism, but now we must ask whether collective bargaining will get us where we want to go." In the proposal, he urged teachers to work towards "(1) a national examination to limit entry into teaching; (2) a system that would allow students to choose the public schools they attended so they would no longer be captive clients; (3) impartial panels of experienced teachers to evaluate teachers accused of incompetence; (4) career ladders that lead to supervision by experienced teachers for the development of novices; (5) restructuring education to encourage bright, young people to enter teaching even if they intend to remain only five or six years." Some of what Mr. Schanker says applies only to school teaching, but much is applicable to the practice of health education in all settings, such as the need for career ladders, and related supervision issues, the need for panels to evaluate incompetence, and a restructuring of the system to attract bright, young people.

All of the above indicated how many believed in the need for performance standards for their profession. It is always encouraging when one is struggling to promote an idea to know that others agree with you.

PROBLEMS

We have mentioned several times that there were philosophical differences among health education specialists. One of these is the content/process issue. I believe credentialing activities did a good deal to bring the proponents of both schools of thought together so that today some do understand the other's position. It is clear that both content and process are essential in professional preparation. All health education specialists need knowledge about both diseases and health issues and all need an understanding of the learning/change process. While it would be inaccurate to assume that there is agreement on this issue by all in the field, it has had a good airing and individuals are still grappling with it.

There is a second philosophical difference which we'll label social activism/health education. It will never be healed. There needs to be a separation of one group from the other. There are some preparation programs called health education, which are preparing students to be social activists. But let's not declare the entire role of the health educator to be that of social activism. This group believes their total function is social change; that they should serve the world; and that it is selfish to spend time improving our own skills and knowledge.

When it was announced in 1987 that a credentialing system was about to be launched, a number of these social activists came out of the woodwork and organized a group to try to force a moratorium on the organization of the National Commission for Health Education Credentialing. As one of the leaders of the group told me, "We don't want credentialing." That, of course, was his privilege; some health education specialists did not want credentialing. Furthermore, they claimed not to know about the decade of activities directed toward the establishment of credentialing. However, the information about Task Force activities had been widespread. This group had not attended a meeting about credentialing, had read none of the documents we prepared, and had not responded to any of our correspondence. Some of them who were in school while our work was in process claimed they did not hear about the Task Force from their professors. This is probably true.

All the members of the Task Force were involved in putting out the fires this group lit. Most of the activity was on both coasts, so Dr. Cortese and I were especially busy. In the four meetings I attended in New England with one organizer of the moratorium, most of the health educators asked why the moratorium and what after the moratorium. The responses were not satisfying. The request for the moratorium was not to provide an opportunity to debate the issues, it was a delaying tactic in the hope of destroying the credentialing effort. The Task Force rejected the request.

There were a number of other activities which could have been harmful to Task Force efforts, so we felt a need to address them. We have mentioned the move to promote a registry for preparation programs, and the difficulties related to the Curriculum Guide. Some others were:

(a) In 1982, the Association for Hospital Educators and Trainers (ASHET)

was applying to the Kellogg Foundation for a grant to develop standards for hospital educators. Since we were also applying to the Kellogg Foundation for a grant to develop a credentialing system for health educators, we pointed out to ASHET that the dual application could cause confusion and could result in both proposals being turned down. We made very little headway. I talked with the Executive and wrote to him. Task Force members in Chicago, Elizabeth Lee and Dr. Carlyon, met with him on several occasions, but ASHET was determined to move ahead with development of standards regardless of what the Task Force was doing. In 1985, ASHET set a goal, "to become the nationally recognized professional organization for professionals responsible for community health promotion/education in health care settings and also to become the nationally recognized professional association for those persons responsible for patient education." Since our protestations to the Executive of ASHET relative to the Kellogg grant came to naught, we let this 1985 announcement go by. In time, it appeared that ASHET no longer pursued that goal.

(b) In the Fall of 1983, an announcement crossed my desk about a course being promoted by California Blue Shield for the health engineer. The description of the course was very similar to that of the health educator. We wrote but did not get a response and heard no more about it.

(c) In 1984, a joint committee of AAHE and SOPHE was appointed to assist the Task Force with looking at competencies at the graduate level. This committee, however, turned its attention to developing a separate credentialing system for masters and doctoral students. It took precious time and effort to point out to that committee that it would be destructive to the field to develop a separate system and requested that whatever work they did be done in conjunction with the Task Force. It was clear that members of the committee were not intentionally bypassing the Task Force. In 1984, very few took the Task Force seriously, including some of its members. We reminded this committee that the Task Force was charged, at the First Bethesda Conference, with developing a credentialing system for the profession and this included the profession at all levels.

(d) In 1984, Dr. Neil, a member of the Health Education Department at Loma Linda University and President of the American Association for Health Promotion, proposed a credentialing system for health promotion experts. Dr. Peter Cortese, Task Force Vice-Chair and Dr. Neil's neighbor in California, spoke with him at length about the difficulties in doing so. And, we all talked with him at a Task Force meeting in Anaheim in 1984. Despite this, Dr. Neil was convinced he could develop a credentialing system. He did learn in time that this was not as simple a process as he thought.

This is a free country, as we so often say. People can do what they want to

regardless of what others may be doing. However, the Task Force took its charge from the profession seriously. We felt we had a responsibility to approach those pursuing similar goals to let them know what we were doing and suggest that it would be in the best interest of all to work together. To set up separate credentialing systems which could cause confusion on the part of funding agencies, the public, and professionals was not what this field needed.

ISSUES

COMMUNICATIONS

A major concern of the Task Force from day one was communicating with health educators. In 1979, one of Alan Henderson's first activities was to submit a communication plan to the Advisory Committee. It provided for communicating with the field through professional organizations and individuals and for publication of a variety of articles in professional journals. Part of this plan was carried out while Alan was Staff Director for the two federal contracts — role definition and verification. When we no longer had paid staff, it was left to Task Force members to implement the plan. We did communicate with professional organizations. Each member of the Task Force assumed responsibility for communicating with a specific organization. That involved submitting articles for inclusion in newsletters, requesting time on annual meeting programs, requesting time at board meetings, and meeting individually with the leadership of the organization to inform them directly about the credentialing project.

During the life of the Task Force, some members did a better job of communicating with the organizations for which they were responsible than others. Most did communicate, as is evidenced by the articles in the organizations' newsletters and the programs relative to credentialing at annual meetings.

In 1980, Wilma Dean Henry, then on the CDC staff, revived the idea of round tables for discussing critical issues in the field. Deborah MacIntosh, Assistant to the Project Director, assumed responsibility as national coordinator of the round tables when Wilma Dean became ill and died. Deborah prepared the materials for round table use relative to role delineation, and promoted the organization of round tables with emphasis on recruiting those who do not attend professional meetings and may not subscribe to professional journals. There were 40 to 50 round tables in different sections of the country in 1980 and 1981. This was an attempt to reach the "grass roots" about the early phases of the credentialing process.

Beginning in 1982, the Task Force wrote annually to the presidents of all national professional organizations and all regional and local professional organizations that we could identify. This communication gave an update on our activities. We specifically requested that the presidents of the organization share the information in the letter with their members. Some of the leadership to whom we wrote in 1982, 1983, 1984, and 1985, and again in 1986, with an invitation to attend and then report on the Second Bethesda Conference, did share our letters and reports with their membership, and it was clear that some did not.

In addition to the official communication from the Task Force to professional organizations, individual Task Force members communicated in a variety of ways with many individuals and organizations who contacted them and whom they believed should be informed about the credentialing process.

The Task Force did not succeed in carrying out part of the communication plan that called for the publication of articles in professional journals. Some articles were published by non-Task Force members and a few by members. Time was the problem. All of us had full-time positions, and all of us did staff work

for the credentialing project.

In addition to communicating with practitioners through professional organizations, faculties of professional preparation programs received extensive communications about Task Force activities. Many of these communications were sent to the Chairs of Departments and herein we encountered the same problem as we did with the professional organizations: some chairs shared the information and some did not. The first direct contact with a large group of faculty was the invitation to the Birmingham Conference; the second was the survey undertaken prior to writing the *Curriculum Guide*; the third was a copy of the *Guide* with a user survey; the fourth was a copy of the *Curriculum Framework*; the fifth was an invitation to the Second Bethesda Conference; and the last was a copy of the report on the Conference.

When the Commission was organized in 1988, many said they really didn't know how this came about and asked why they weren't informed. One of the reasons some people were not informed was the failure of the leadership to communicate; another was that many of these individuals who complained did not attend professional meetings nor read journals or newsletters; and in my view, a major reason for individuals not knowing about Task Force activities was that they did not read or did not pay attention to information which was given to them, because, at the time, they were not interested. As we met with local and national professional organizations, we heard people say: "Oh, I got that in the mail, but figured nothing would come of it so I threw it away", or "Oh, I got that in the mail and I put it on the bottom of the pile. I'm going home and read it", or "You mean, this thing is really going to happen?"

It was clear to us that the idea that this profession was getting organized seemed so unlikely to so many that they didn't take us seriously.

On the other hand, we received a great deal of spontaneous support. People called or wrote to say thank you, this is great, keep up the good work. And there were those who wrote and said we were crazy, didn't know what we were doing, etc. There were times when I totally agreed with that.

In summary, communicating with all health education specialists in the country is not easy. There is no one professional organization. There is not a list of professional health educators; our resources were limited. Given what we had to work with, and our limited resources, we did get the information out. We could not control what was done with it.

CONTENT

We are indebted to the American School Health Association for bringing the content issue to our attention and for persisting in requesting a statement relative to it. The issue was this: The *Curriculum Framework* did not deal with content, i.e., health topics, such as nutrition, sexuality, chronic disease, communicable disease, the typical areas around which health educators build programs/curriculum. It was the position of the School Health Association that the *Framework* should include these topical areas. This was also the position of some of those attending the regional workshop about the *Curriculum Guide.*

The Task Force held that topical areas were not competencies, they are infor-

mation, knowledge about health/disease issues which must be included in professional preparation programs. The *Framework* deals with competencies, which are not the total curriculum. Students should come to a health education major with basic anatomy and physiology, knowledge of the scientific process and of the health/disease process. And they must learn, during their professional preparation, about current disease problems and health issues. Given the great number of the latter, it would not be possible to include all of them in a curriculum.

The health education specialist applies the competencies to health/disease issues such as prevention or to a topical area such as sexuality. The issues with which a health educator works depend on the needs of the community and the health problems of the day. The latter change constantly. AIDS is a good example; it was not heard of 15 years ago.

Needs differ from community to community. In one community, a fifth grade teacher may teach nutrition and in another, how to cope with drug dealers. No health education specialist can be expected to know all there is to know about all possible topical areas or issues. What is needed is basic principles of epidemiology, so practitioners will know what questions to ask should they be required to teach or develop a program around a topic or issue with which they are not familiar. For example, for a disease (arthritis), some of the questions are: what is or are the causes, what is the prognosis, what is the preferred treatment, are there special populations which are affected by it, etc. For health issues (e.g., running): what are the known benefits, what are the known problems, to what age group does this apply, is special equipment needed, etc.

To resolve this issue, the Task Force appointed a committee of two school health educators and two community health educators to develop a statement relative to content to be included in the revised edition of the *Curriculum Framework*. The committee was chaired by Dr. Ann Nolte, Illinois State University, Normal, Illinois.

WORKING WITH EMPLOYERS OF HEALTH EDUCATORS

We did not work with employers. It is not that we were not aware of the need. It was that we were not sure what we had to sell. The variety in professional preparation programs, referred to above, made it impossible to tell employers what they could expect from a health education specialist.

We mentioned that an employer, speaking at the Second Bethesda Conference, said most health educators were not prepared to do the work expected of them at the entry level. Prior to the conference, when meeting with staff of the federal agencies to discuss funding, we received a similar message. It is important to note that these staff were all health education specialists, interested in and anxious to advance the profession. I quote from my notes of that meeting:

> We got a very clear message from this meeting with the feds, that is, most health educators are not properly prepared to fill positions available in health education. These positions are being filled by psycholo-

gists, other social scientists, and a variety of other professions. The message was clear: *We must improve the quality of preparation at both the undergraduate and graduate levels.*

It was our observation that graduates of preparation programs which prepared them to meet the expectations of employers had little difficulty finding positions. These "model" programs needed to be identified and analyzed to help others improve the quality of professional preparation. We considered doing this many times, but it never came about. There was neither time, money, nor energy.

WHAT IS ENTRY LEVEL?

We mentioned above that the federal contract required that the verified role be defined at an academic level, and with reluctance it was defined in 1981 at the bachelor level. After the Second Bethesda Conference, this was changed to "entry level," meaning that an individual should be able to use the competencies on entering the profession. This definition came about because individuals enter this profession at both the bachelor and master level. This should not be! *The profession needs to decide when an individual is prepared to enter the health education work force.*

Questions were raised many times during this project as to whether the competencies could be taught at the undergraduate level; some felt we were expecting too much of the undergraduate programs. It was, and is, my opinion that these competencies can be taught at the undergraduate level but not in any depth. Advanced training at the graduate level and extended field experience is needed before a student can have a good understanding of the application of the competencies in the real world of practice. Further, competencies are only part of the curriculum. Other knowledge and skills are necessary to be a health education specialist.

A graduate of a bachelor program can be hired in a beginning level health education position provided s/he is supervised by an experienced health education specialist. Supervision of the beginning level worker is a major missing link in the practice of this profession.

In relation to this issue, a health education specialist wrote the following to us after the Second Bethesda Conference:

> Special attention needs to be directed...to the recent Carnegie Report and recommendations for the preparation of teachers in general which includes a 4 year degree in your major field followed by a fifth year for an education degree and a sixth year for a teaching internship. In essence, the entry-level teacher would need 6 years of training. Our field needs to be aware of the impact for training if this is adopted as a standard for teachers.

The Carnegie Report had very little good to say about undergraduate preparation in education, regardless of the branch of education. Although it dealt with teaching in schools, its recommendations can be applied as well to those health

educators working in other settings.

The Report is clear: an educator cannot be fully prepared at the bachelor level. In my view, that is certainly true of health education specialists, regardless of the setting in which they work.

UNIFICATION OF THE PROFESSION

In 1983, an AAHE/SOPHE committee was appointed to consider "unification" of the profession. This could be interpreted as a merger of the two organizations or an informal liaison or anything in between. The purpose of unification was to have one voice to speak for the profession on critical issues. The Joint Committee, as it was known, met faithfully for a few years. The Task Force kept tabs on these deliberations because we saw this work as relevant to Task Force goals. To my knowledge, the committee has not been disbanded nor has it been active in recent years. This is unfortunate.

In my view, the lack of one national professional organization parallels professional preparation as the most critical issue with which the profession must deal. The numbers in our profession will always be relatively small. We cannot afford the confusion created by more than one national organization. Students, potential members, legislatures, employers, funding agencies, and others can be forgiven for assuming that we do not have our act together.

CONCLUSION

I got involved in the credentialing effort because I believed that education was the most promising intervention available today for the prevention of disease and the promotion of health. I still believe that. If professional educators are to make a contribution to the nation's health, the profession must agree on the primary function of the health education specialist. I believe it is to apply the learning/change process to health and disease issues. We are not specialists in health/disease issues, although we are certainly knowledgeable about them. Nor are we social activists, although we do play that role at times. We are specialists in education as it is applied to health and disease. When there is agreement on the conceptualization of the role of the health education specialist, issues such as professional preparation, entry-level, career ladders, and supervision will fall in place.

The need for unified leadership to bring this about is clear. The potential for unified leadership is there; someone has to care enough to make it happen. I do hope there is someone who will do that.

The credentialing project helped to highlight these issues for the profession. It can help in the solution, but it cannot carry the burden alone.

REFERENCES

Cleary, H. P. (1986) "Issues in the Credentialing of Health Education Specialists: A Review of the State of the Art," in *Advances in Health Education and Health Promotion*, (A) 129-154, Jai Press, Inc.

Conant, R. M. (1978) "A Credentialing Concept," in *Preparation and Practice of Community, Patient and School Health Educators: Proceedings of the Workshop on Commonalities and Differences,* February 15-17, DHEW Publication (HRA), 78-71.

Creswell, W. H. (19??) "Professional Preparation: An Historical Perspective," *Proceedings; National Conference for Institutions Preparing Health Educators,* DDHS Publication No. 81-50171.

DHHS Publication No. (HRA) 80-84-1980. Initial Role Delineation for Health Education, April.

DHHS Publication No. 81-50171. (1981) National Conference for Institutions Preparing Health Educators, February 5-7, Birmingham, AL.

Garton, P., Barnes, R., & Mehne, P. (1984) "Experience with Competency Based Curriculum Design: A School and Community Health Model," *Health Education,* May.

Green, L. W. (1976) "Suggested Procedures for Moving from Programmatic Accreditation to Peer Review Under Broader Institutional Accreditation," *Health Education Monographs*, (4)3, 278-284.

National Center for Health Education, National Task Force on the Preparation and Practice of Health Educators, Inc. (1986) *Quality Assurance in Health Education; Proceedings of the Second Bethesda Conference,* February 24-26.

U.S. Department of Commerce, National Technical Information Service. (1982) *Role Refinement and Verification for Health Educators; Final Report.* Access No. CHRPS 09-04273, Springfield, VA.

APPENDIX A

THE DEVELOPMENT OF NATIONAL CERTIFICATION FOR HEALTH EDUCATION SPECIALISTS

A Chronology of Events

1970s

- Accreditation of professional preparation programs existed.

  The National Council for Accreditation of Teacher Education (NCATE) accredited programs preparing teachers of health education.

  The American Public Health Association (APHA) accredited Masters degree programs in Community Health Education outside of Schools of Public Health and passed that function on to the Council on Education for Public Health (CEPH) when it was created in 1976. CEPH also accredits Schools of Public Health.

  A Society of Public Health Education Committee was developing standards for a program approval process for undergraduate community health education.

- No national credentialing of individual health educators for either school or community settings existed, although there was growing activity on the part of professional organizations pointing to the need.

  Several conferences on professional preparation and practice were sponsored by the association for the Advancement of Health Education.

  The Society of Public Health Education Committee on Preparation and Practice updated its 1967 report: Guidelines for the Preparation and Practice of Health Educators. (1976)

  The Coalition of (8) National Health Education Organizations with funds from the Centers for Disease Control (CDC) issued a report on Current Status and Needs for Health Education Standards and Recommendations for Action. (1977)

- National professional health education organizations collaborated in a Workshop on Commonalties and Differences in the Preparation and Practice of Health Educators, Bethesda, Maryland, funded by the Health Resources Administration, DHEW. (First Bethesda Conference 1978)

- The National Task Force on the Preparation and Practice of Health Educators, Inc., was established for the purpose of developing a credentialing system. (1978)

  The initial Role Specification for Entry-level Health Educators was developed.

1980s

- Role verification and refinement. (1980)

- National Conference for Institutions Preparing Health Educators, Birmingham, Alabama. (1981)

- Curriculum development begins. (1981)
- Dissemination of draft, "A Guide for the Development of Competency-based Curricula for Entry-level Health Educators." (1983)
- Nationwide regional workshops for university and college faculty and employers of health education were held to orient them on the Guide. (1984-85)
- Dissemination of revised document, "A Framework for the Development of Competency-based Curricula for Entry-level Health Educators. (1985)
- Workshop on Quality Assurance in the Delivery of Health Education Services: Credentialing the Health Education Specialist, Bethesda, Maryland. (Second Bethesda Conference, 1986)
- Development of a Model for Continuing Professional Development of Health Educators. (1987)
- Establishment of National Commission for Health Education Credentialing, Inc. (NCHEC). (1988)
- Charter Certification Phase was initiated: 1558 Health Education Specialists certified through examination of credentials. (1989)

  First election held for Division Board Directors and at-large Commissioners. (1989)
- Item Writing and Examination Construction Workshop. Professional Examination Service (PES) coordinated the item writing by health educators and developed the examination for certification of health education specialists. (1989)

1990s

- First certification examination for Health Education Specialists a 16 U.S. sites. 644 candidates passed and became CHES. (1990)
- Examination item writing continues. (1990)
- Planned presentations at national meetings in order to provide information for and communication with professional members. (1990)

AAHE	New Orleans
SOPHE	New York City
ASHA	Long Beach, CA
ACHA	San Antonio, TX

- Procedures for Continuing Education System developed.

  Provider Designation Handbook and Recertification Handbook for CHES published (1990)
- Solicitation of Multiple Event Providers and Single Event Providers began. (1990)
- Eight providers were designated to conduct programs of continuing education contact hours (CECH) for health educators. (1991)

  AAHE
  ASHA

ACHA
Arizona Department of Health Services
New Jersey Graduate Program in Public Health, UMDNJ/Robert Wood Johnson Medical School
Society for Public Health Education, Inc.
Western Illinois University Department of Health Services

- Executive Director employed by NCHEC, Inc. (1991)
- CHES examination given at 37 U.S. Sites and 5 alternate sites, 1312 candidates passed and became CHES. (1991)
- NCATE adopts NCHEC responsibilities and competencies for accreditation of programs preparing teachers of health education. AAHE is asked to assume the role of reviewing materials for this NCATE review. (1991)
- First CHES Directory published containing the names of individuals certified as Health Education Specialists. (1991)
- CHES examination given in 10 sites, 199 passed and became CHES. (1992)
- New Designated Continuing Education Contact Hour Providers include: (1992)

  Department of Health an Human Services, national Heart, Lung, and Blood Institute
  Indiana State Board of Health, Division of Health Education
  Youngstown State University

- NCHEC now has a Board which is completely elected. Transition from Task Force completed. (1992)
- Two issues of the *CHES Bulletin* published. This is a newsletter to maintain communication with CHES yearly. (1992)
- NCHEC pilot project: developed program to work directly with colleges and universities arranging for NCHEC test sites. Purpose: to increase accessibility, increase involvement of Health Education Faculty and to reduce costs.

  In 1993, had a total of 19 test sites—12 NCHEC sites, 7 PES sites. 324 candidates passed the examination.

- CHES network established in 42 states and territories with one or more CHES.
- Designated Providers:

  131 Single Event Providers through 1994.
  39 Multiple Event Providers through 1994.

- Elected six new Division Board Members and Commissioners. (1994)
- NCHEC office moved to Room 677 in the same building. NCHEC is becoming functionally independent.
- Directors Liability purchased. (1993)

- Three Item Writing conducted: Portland, Oregon; North Carolina: and Atlanta, Georgia. (1994)
- Provider Handbook Renewal and Recertification Books revised, printed, and distributed. (1993-1994)
- Waiver program established for the Charter group recertifying in 1994.
- The Framework is being reformatted.
- NCHEC policies reviewed by Boards and Commissioners. Being organized for quick reference and yearly review.

APPENDIX B

DEFINITIONS OF CREDENTIALING TERMINOLOGY

Accreditation

Accreditation is a process by which a recognized professional body evaluates an entire program against predetermined criteria or standards.

Licensure

Licensure is concerned with protection of the public. It is a process by which an agency of government (usually a state) grants permission to individuals to practice a given profession by certifying that those licensed have attained specified standards of competence.

Certification

Certification is a process by which a professional organization grants recognition to an individual who, upon completion of a competency-based curriculum, can demonstrate a predetermined standard of performance.

APPENDIX C

LISTS OF COMMITTEES AND TASK FORCE MEMBERS

INITIAL ROLE DELINATION FOR HEALTH EDUCATION
1978-1980

Role Delineation Project Staff

Alan C. Henderson, Dr.P.H., Project Director, National Center for Health Education

Deborah V. McIntosh, M.P.H., Research Assistant, National Center for Health Education

Ronald K. Hambleton, Ph.D., Project Consultant, Laboratory of Psychometric and Evaluative Research, University of Massachusetts

Role Delineation Advisory Committee

Helen P. Cleary, D.Sc., Committee Chair, Department of Family and Community Medicine, University of Massachusetts Medical School

Peter A. Cortese, Dr.P.H., Committee Vice-Chair, Office of Comprehensive School Health, U.S. Department of Education

John J. Burt, Ed.D., Department of Health Education, University of Maryland

William H. Carlyon, Ph.D., Department of Health Education, American Medical Association

Robert H. Conn, Ed.D., M.P.H., Department of Human Resources, District of Columbia

Elizabeth Lee, R.N., M.S.N., Center for Health Promotion, American Hospital Association

Robert J. McEwen, S.J., Department of Economics, Boston College

Mabel Robinson, Ed.D., M.P.H., Department of Education, State of Alabama

Helen S. Ross, Ed.D., M.P.H., School of Applied Arts and Sciences, San Jose State University

Warren E. Schaller, H.S.D., Department of Physiology and Health Science, Ball State University

Leonard Tritsche, M.S., Department of Education, State of Oregon

Joan Wolle, Ph.D., M.P.H., Health Education Center, Maryland State Department of Health and Mental Hygiene

Role Delineation Working Committee

Loren B. Bensley, Jr., Ed.D., Department of Health Education, Central Michigan University

Forrest E. Conner, Ph.D., Education Consultant

*William Darity, Ph.D., School of Health Sciences, University of Massachusetts

*Margo de la Vega, M.S.E., M.P.H., Consultant in Patient Education

Godfrey M. Hochbaum, Ph.D., Department of Health Education, School of Public Health, University of North Carolina

Marshall Kreuter, Ph.D., Bureau of Health Promotion and Protection, Utah Department of Health

Betty Mathews, Dr.P.H., School of Physical and Health Education, University of Washington

Elena M. Sliepcevich, D.P.E., Department of Health Education, Southern Illinois University

Beverly G. Ware, Dr.P.H., Corporate Health Education Programs, Ford Motor Company

*Resigned from the Committee

ROLE REFINEMENT AND VERIFICATION FOR ENTRY LEVEL HEALTH EDUCATORS
1980-1981

Project Staff

Alan C. Henderson, Dr.P.H., Project Director, National Center for Health Education

Deborah V. McIntosh, M.P.H., Project Associate, National Center for Health Education

Ronald K. Hambleton, Ph.D., Project Consultant, University of Massachusetts

Role Verification Committee

Laura Anderson, M.P.H., Berkeley California Health Department

Elizabeth Bernheimer, M.P.H., School of medicine, University of Nevada

Chet Bradley, M.S., Wisconsin State Department of Public Instruction

Carol Feight, M.A., West Intermediate School, Mt. Pleasant, MI

Alan W. Grubb, Ed.D., Deaconess Hospital, Evansville, IN

Godfrey M. Hochbaum, Ph.D., School of Public Health, University of North Carolina

Herb Jones, H.S.D., Department of Physiology and Health Science, Ball State University

Marsha Pinkett-Heller, M.P.H., School of Public Health, Columbia University

Anna Skiff, M.S.P.H., U.S. Public Health Service Hospital, Statten Island, NY

Wendy D. Squyres, Ph.D., Kaiser-Permanente Medical Center, Oakland, CA

Role Verification Advisory Committee

Helen P. Cleary, D.Sc., Chair, University of Massachusetts Medical School

Peter A. Cortese, Dr.P.H., Vice-Chair, California State University, Long Beach

William H. Carlyon, Ph.D., American Medical Association

Robert H. Conn, Ed.D., M.P.H., District of Columbia, Department of Human Resources

John H. Cooper, P.E.D., George Mason University

Elizabeth Lee, R.N., M.S.N., American Hospital Association

Robert J. McEwen, S.J., Boston College

Mabel C. Robinson, Ed.D., M.P.H., University of Alabama

Helen S. Ross, Ed.D., M.P.H., San Jose University

Warren E. Schaller, H.S.D., Ball State University

Leonard Tritsche, M.S., Department of Education State of Oregon

Joan Wolle, Ph.D., M..P.H., Maryland State Department of Health and Mental Hygiene

NATIONAL TASK FORCE ON THE PREPARATION AND PRACTICE OF HEALTH EDUCATORS
1978-1988

*John Burt, Ed.D.
*Helen Cleary, D.Sc.
Chair, Founder
*Peter Cortese, D.Ph.,
Vice-Chair, Co-Founder
*William Carlyon, Ph.D.
William B. Cissell, Ph.D.
John Cooper, Ed.D.
Bryan Cooke, Ph.D., M.P.H.
*Robert H. Conn, Ed.D.
Wanda H. Jubb, Ed.D.
Elizabeth Lee, R.N., M.S.N.
Rev. Robert McEwen, SJ
*Mabel Robinson, Ed.D.
*Helen S. Ross, Ed.D., M.P.H.
Helen Savage
*Warren Schaller, H.S.D.
Becky J. Smith, Ph.D.
Leonard Tritsch, M.S.
Alyson Taub, Ed.D.
Elaine M. Vitello, Ph.D.
*Joan M. Wolle, Ph.D.

Anna Skiff, M.P.H., Volunteer Staff

*Original Task Force Members

NATIONAL COMMISSION FOR HEALTH EDUCATION CREDENTIALING, INC.

Board of Commissioners—Chairs

Peter Cortese, Dr.Ph., CHES (1988-1989)—Chairperson
Elaine Vitello, Ph.D., CHES (1990)—Chairperson
Beverly G. Ware, Dr.Ph., CHES (1991-1992)—Chairperson
Patricia D. Mail, M.P.H., CHES (1993-1994)—Chairperson

Division Board Coordinators

Emily Tyler, M.P.H., R.H.Ed., CHES (1994)—Division Board for Certification of Health Education Specialists
Barbara A. Cooley, M.A., CHES (1993)—Division Board for Certification of Health Education Specialists
Lorraine G. Davis, Ph.D., CHES (1992)—Division Board for Certification of Health Education Specialists
Elaine M. Vitello, Ph.D., CHES (1990-1991)—Division Board for Certification of Health Education Specialists
Barbara Giloth, M.P.H., CHES (1990-1992)—Division Board for Professional Development
Ann E. Nolte, Ph.D., CHES (1993-1994)—Division Board for Professional Development
Brad Neiger, Ph.D., CHES (1994)—Division Board for Professional Preparation
Robert M. Huff, Ph.D., CHES (1990-1993)—Division Board for Professional Preparation

Staff

Marilyn E. Schima, M.P.H., Ed.D., CHES (1991-1995)—Executive Director
Alyson Taub, Ed.D., CHES (1989-1991)—Volunteer Executive Director

APPENDIX D

RECOMMENDATIONS OF THE FIRST BETHESDA CONFERENCE

The participants presented recommendations for the future direction of health education in relation to preparation and practice of the total field, regardless of practice setting or specialty focus. These recommendations represent consensus on the part of the group and were viewed as positive action oriented steps to achieving a unified and acceptable approach for examining the preparation and practice of professional health educators.

- That each member organization of the Coalition assume responsibility for disseminating the proceedings of this Workshop. And that each group identify the implications of this Workshop for its own membership an explore the resources that it can commit to achieving the necessary follow-up to the Workshop.

- That the Planning Committee for this Workshop become a National Task Force on the Preparation and Practice of Health Educators. And that Members of the Planning Committee continue to serve on the Task Force, subject to approval by the Organizations they represent.

- That the Task Force, including a representative from the Office of Education, be charged with the responsibility for developing a plan of action leading to a credentialing program within a specific time frame for the total field of health education. Specifically, the Task Force will:
  - serve as a liaison with health education organizations, and with pertinent government office, including the Bureau of Health Manpower, and the Bureau of Health Education
  - establish priorities
  - seek funding to support a credentialing effort.

- That the plan of action developed by the Task Force lead to:
  - a survey of field practice including a synthesis of existing research
  - a concrete statement of the state-of-the-art of health education
  - an assessment of health educator competencies
  - development of performance criteria
  - delineation of performance criteria
  - delineation of core curriculum requirements for both entry level and specialized health educators.

- That government programs and private agencies with health education components require staffing by qualified health educators.

BEST COPY AVAILABLE